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UNIVERSITY OF ALBERTA

Women And The Struggle For Well-Being

by

© Cathy van Ingen

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF Master of Arts

Department of Physical Education and Sport Studies

Edmonton, Alberta

Fall, 1994

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Dr. D. Shogan

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Date SEPTEMBER 6 1994

Abstract

The purpose of this study was to examine violence as an obstacle that many women face in their daily struggle for well-being.

A textual analysis of three "representative" Health and Welfare Canada documents on women's health and well-being was undertaken to determine how violence was addressed in these materials.

A focus group using five active female athletes was conducted in order to articulate some of women's experiences with the fear of violence in their participation in physical activity. The interview highlighted strategies used by women in order to participate in physical activity despite fears of violence. An ethnographic summary of the interview is included.

An examination of feminist health materials which describe an alternative method of health promotion which actively resists cultures of violence by locating the area of women's health within a wider social, political and economic context.

To overcome the difficulties which many women face in their search for well-being, several recommendations were directed at health educators and at the physical education profession.

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CHAPTER I

INTRODUCTION

It is impossible to discuss women's well-being without analyzing the "underlying factors of women's social and economic inequality" (Brown 1989, p. 9). Political activist and author Rosemary Brown states:

> I believe that the search for well-being is not a personal but a political one...We should focus more clearly on those factors in the world in which we live which are obstacles to the actualization of our full potential as well as the factors that would give us more control over our existence. I would suggest that we remind ourselves that the 'personal is political'
>
> (Brown 1989, p. 9)

There is an urgent need to address the obstacles that many women face in their daily struggle for well-being. One of the most distressing issues is the reality of violence in many women's lives. Violence against women is a problem of indisputably high magnitude. In 1980, Linda Macleod's report on violence against women, Wife Battering in Canada: The Vicious Circle, showed that one out of every ten women are battered.

Women encounter violence from two different groups, companions and strangers. However, the vast majority of violence that women experience is committed by the men with whom they live. Women are physically brutalized "not by strangers who are breaking into their homes or who accost them on dark streets, but by husbands and lovers..." (Macleod 1987,

p. 3). In 1993 the Globe and Mail reported that "between 22 and 35 percent of all visits by females to U.S. emergency rooms are injuries from domestic assaults" (Hatch 1993, p. A9). It is this 'companion' violence "which transforms so many Canadian household into prisons" (Macleod 1987, p. 17). It is therefore essential that any health directive aimed towards women and their well-being take into account violence against women both in and out of the home.

Wife/Spousal Abuse

Wife assault is an unacceptable form of criminal behaviour. Yet, just eleven years ago, "wife battering was still a laughing matter for some of Canada's political leaders" (Macleod 1987, p. 3). Linda Macleod writes, "On May 12, 1982, when the problem of wife battering was raised in the House of Commons as a serious and widespread reality suffered by one out of every ten Canadian women, laughter echoed through the House" (Macleod 1987, p. 3). It is now generally recognized that women are often terrorized by the men in their lives. Despite the fact that wife assault is recognized as unacceptable, it still endures pervasively. The following definition of wife battering is taken from Linda Macleod's study on violence against women entitled Battered But Not Beaten:

> Wife battering is the loss of dignity, control, and safety as well as the feeling of powerlessness and entrapment experienced by women who are direct

> victims of **ongoing or repeated** physical, psychological, economic, sexual and/or verbal violence or who are subjected to **persistent** threats or the witnessing of such violence against their children, other relatives, friends, pets and/or cherished possessions, by their boyfriends, husbands, live-in lovers, ex-husbands or ex-lovers, whether male or female (1987, p. 16).

It is impossible for battered women to achieve well-being while living in terror within their own homes. Using the research that one in ten women are abused by their partner and applying this to Alberta's population, there are 55,000 women who are potential victims (Robertson 1986, p. 40). Generally speaking, the attacks are intermittent, yet numerous and range in severity from punches and slaps to kicks, and more serious injuries, even death. In 1976, Statistics Canada documented that "Of all the Canadian female homicide victims, 60% are killed within a family context" (Ontario Medical Review 1988, p. 3). American statistics from 1982 reveal that "four out of five women who are murdered are killed at home" (Schechter 1982, p. 173).

Because so many women are battered there are not enough shelters to house the women who seek help. In Alberta, there are fourteen women's emergency shelters that offer short term accommodation for abused women and their children. Almost all shelters in Canada and the United States have to turn away battered women because of lack of space. In some shelters one request is turned down out of every two made. For other houses the ratio is higher. In Toronto, one house "turned

away ten women for every one they sheltered" (Macleod 1987, p. 7). In Philadelphia it is estimated that shelters "take in 1 out of every 20 callers, while in New York City 85 out of every 100 women are denied services because of space shortages" (Schechter 1982, p. 224). As staggering as these figures are, it is far from representing the total number of battered women, because only a portion of battered women seek shelter in transition houses. Typically, the battered women who seek to use shelters are young and poor (Macleod 1987, p. 19). In Alberta the women who use shelters share the following characteristics: the women are young (on average 29 years old), live in an urban centre, work full time in the home, have 1-2 young children and are educated to the level of grade 9 to 12 (Alberta Social Services, 1988). These statistics do not give an accurate picture of who is battered as aboriginal women, immigrant women, and other women of color are not represented. As well, women from other socio-economic backgrounds are not included.

For many women, living with violence is a reality with little chance for escape. Many women who leave violent men find themselves economically vulnerable and are forced to return home. In Canada current statistics show that "within one year of separation, a women's household income plummets by 70%, while a man's disposable funds increase by 43%" (CACSW, 1987, p. 11). In the United States one out of every three female-headed households, as compared to one out of every

eighteen male-headed households, is living below the poverty level (Schechter 1982, p. 226). Also, women with children often do not receive child support payments if they leave their husbands. On average the courts "do not order fathers to pay child support in over 40% of the cases when the mother retains custody" (French 1992, p. 183). In almost all cases the payments are inadequate and do not cover basic child care expenses. In 1985 in the United States, "only 25 percent of the 8.8 million men required to pay child support paid it" (French 1992, p. 183). Often women are left with no recourse than to remain with the abuser.

Even if a woman does have financial resources available to her does not mean she can escape. Leaving the home of an abuser does nothing to guarantee safety and may spark further violence. The following excerpt is taken from Marilyn French's book The War Against Women:

> Almost every day, a man kills a woman who has left him for beating her, who has struggled within the system, getting a court order enjoining him from approaching her. ...Indeed, Department of Justice [U.S.A.] statistics show that 75 percent of reported assaults against wives or lovers are committed after separation (1992, p. 188).

Current estimates now predict that "as many as half of all women in the United States will experience violence at some time in their marriage" (Hatch 1993, p. A9). Women stay in these assaultive relationships for a variety of reasons. Battered women display common characteristics, such as poor self image and feeling of personal helplessness to change

their situation (Ontario Medical Review 1988, p. 12). The negative impact on women resulting from abusive relationships is immeasurable. It is important that we stop asking "Why does she stay?" and start asking "Why does he batter?". Wife battering is not an isolated case of physical violence. "It is the license society gives a man to use violence against his wife without fear of retribution - he may never take this license, but he possesses it nonetheless" (Macleod 1980, p.66). There is an urgent need for programs and services that will work towards creating a radical change in the status of women. Until this time, women will remain vulnerable to violence, particularly from their spouses. Women can not control their own existence and strive for personal well-being until the issue of violence against women is at the forefront of the public agenda.

Rape

> RAPE IS AN ACT OF AGGRESSION in which the victim is denied her self-determination. It is an act of violence, which, if not actually followed by beatings or murder, nevertheless always carries with it the threat of death. And finally, rape is a form of mass terrorism, for the victims of rape are chosen indiscriminately, but the propagandists for male supremacy broadcast that it is women who cause rape by being unchaste or in the wrong place at the wrong time - in essence, by behaving as though they were free (Schechter 1982, p. 36).

The fear of rape lies within the hearts of many women. The magnitude of this threat is enormous. Sexual crimes committed against women are a major obstacle to the

actualization of personal well-being. Half of our female children will be subjected to unwanted sexual acts before they are eighteen years old (Eccles 1990, p. 34). Rape "constitutes a deliberate violation of emotional, physical and rational integrity and is a hostile, degrading act of violence" (Brownmiller 1975, p. 376). Yet, rape is the least punishable offence under the Canadian Criminal Code (C.A.S.W. 1976, p. 4). In 1981, only 5 per cent of reported rapes actually resulted in a conviction (Fein 1981, p. 2). In 1983 changes were made to Canada's sexual assault legislation, Bill C-127, in an attempt to improve the treatment of cases of sexual assault. However, in 1985 the Canadian Urban Victimization Survey found that only 38 per cent of incidents of sexual aggression were reported to the police (Dept. of Justice 1990, p. 3).

In the 1960's the FBI's Uniform Crime Reports called rape "the most under reported crime" (Brownmiller 1975, p. 387). In Canada, thirty-three years later sexual assault is called "the most pressing problem confronting the criminal justice system in Canada" (Dept. of Justice 1990, p. 44). Estimates show that of the reported rapes, strangers commit only one half of the offenses (Brownmiller 1975, p. 400). This means that women are being violated by men with whom they have a relationship, including male family members. Statistics show that one in four girls will be bribed, tricked, threatened or forced to have sexual contact with someone they know and trust

(Eccles 1990, p. 34). "Recognizing that rapists are in no significant sense different from other men does not make the act less horrible. Rather, it brings into question the society in which ordinary men CAN be rapists" (Mebea and Thompson 1974, p. 27).

Until January 1983, Canadian law granted a man an absolute right to sexual access to his wife. Legally, he could force her to submit with a knife at her throat (CACSW 1986, p. 2). In Canada, it has only been illegal for a man to rape his wife for the last ten years. Unfortunately, even after the 1983 legislative reforms there is still great reluctance to report the crime and seek legal justice. Rape, in Canada, is included under the general heading of sexual assault, so there are no statistics that reflect the number of rape offenses. In 1988, there were 29,111 reports of sexual assault made to police in Canada (Dept. of Justice 1990, p. 12). Yet, this figure grossly underrepresents the actual existence of rape in Canada. Currently, in some states in the U.S., such as Oklahoma, it is still legal for a man to rape his wife (Reifenberg 1993, p. A3).

National statistics show that women are highly at risk for sexual assault. The fear of abuse is exceptionally high in dating relationships. In a national study completed by two Carleton University sociologists, 81 per cent of the women questioned had been subjected to sexual, physical or psychological abuse by a dating partner. The survey was given

to 3,142 students; 1,835 women and 1,307 men at 44 Canadian campuses. The results showed that 28.8 per cent of the women had been sexually abused within the last year, and 45.8 per cent had experienced sexual abuse at some point in their lives (Downey 1993, p. A1).

Rape and sexual assault are obstacles that many women face in their daily struggle for well-being. With this reality many women live a life of fear. As is often the case, attention is largely focused upon women and the type of precautions that can be taken as individuals. Women are told, both implicitly or explicitly, to engage in protective behaviors. For example, women deny or obscure their personal identity by only listing their first initial and last name in the phone book. This adds security to a woman's life by keeping her sexual identity ambiguous. Women are also advised to secure their independence by being accompanied by men whenever possible, especially at night. Other safety measures include checking the car before entering and then locking the doors and keeping the windows rolled up. It is as though women's ultimate security lies in direct opposition to the amount of freedom and independence that men routinely enjoy.

Contrary to popular belief, the answer to women's safety does not lie in women sustaining a high level of suspicion. "Imposing a special burden of caution on women is no solution at all. There can be no private solutions to the problem of rape" (Brownmiller 1975, p. 400). Rape is a societal problem

that directly impacts women's health. In this regard using the "lifestyle" approach to health is totally ineffective. Women can change and limit their behaviour but as Susan Brownmiller argues:

> ...not only does the number of potential rapists on the loose remain constant, but the ultimate effect of rape upon women's mental and emotional health has been accomplished <u>even without the act</u>. For to accept a special burden of self-protection is to reinforce the concept that women must live and move about in fear and can never expect to achieve the personal freedom, independence and self assurance of men (1975, p. 400).

Acts Of Misogyny In Canada

In Canada, an act of male violence against women occurs every six minutes. Half of these acts occur in broad daylight (Eccles 1990, p. 34). Continuously, women are subjected to acts of violence. Not all are life threatening, but these relentless attacks fit into the larger picture of violence against women. Women are concerned with the widespread violence and fear in their daily lives, yet, women continue to struggle to find a place of equality and respect in our society. Health promotion must be inclusive of women's common daily experience of fear and/or violence.

All too often in our society attention is focused on the individual, and not the problem of male violence in women's daily lives. A disturbing example of this is the Montreal Massacre. On December 6, 1989, twenty-five year old Marc Lepine used a semiautomatic rifle to kill young women at the

University of Montreal's Ecole Polytechnique. Before opening fire Lepine shouted, "You're all a bunch of feminists, and I hate feminists" (Came 1989, p. 14). Over the course of twenty minutes 14 women were killed before Lepine took his own life. In a three-page suicide note, Lepine blamed women for destroying his life. Marc Lepine did not know any of his victims, but because they were female he felt he had sufficient cause to justify his actions.

After the massacre Lepine's actions were often written off as being one specific incident and not related to a societal problem. The problem with "representing Lepine as irrational effectively camouflages the relationship between his actions and the 'rational' practices that maintain male privilege and power in the everyday, routine aspects of our lives" (Newson 1991, p. 94). As Sylvie Gagnon says in the video "After The Montreal Massacre", "Marc Lepine is a symbol of death and hate... he is a problem, not an individual" (N.F.B., 1991). Marc Lepine's expression of violence-prone male hostility against women is tragically commonplace. His actions are a symbol of male antagonism towards women. This is the social and political reality in which women live.

Violence against women is the most pervasive yet least recognized human rights issue in the world (Bunch 1991). Every day women suffer violence at the hands of men. Until this civil emergency is recognized and addressed, women will continue to struggle with the ineffectiveness of traditional

approaches to health. The World Health Organization describes health as "the extent to which an individual or group is able ... to realize aspirations or needs and ... to change or cope with the environment" (C.A.C.S.W. 1989 p. 3). However, the world community does not even acknowledge women as having aspirations or needs. The environment in which women live largely ignores or disregards women's physical, emotional, spiritual, mental, political and economic well-being.

Limitations Of Traditional Approaches To Health

At the first International Conference on Health Promotion, held in Ottawa on November 21, 1986, a new public health movement was created. This movement promoted health as "a state of complete physical, mental and social well-being" (WHO 1987, p. 1). Health, according to Health For All by the year 2000, is not defined as merely the absence of disease; it is a part of everyday living. "The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equality" (WHO 1987, p. 1). These prerequisites for health are inextricably tied to one's surroundings. This approach has important implications for women whose life experiences are inadequately addressed in traditional approaches to women's health and well-being.

A more holistic approach to women's well-being is required, one that encompasses physical, emotional, social,

environmental, political, and economic health. While issues such as domestic violence and rape appear to be outside the domain of the traditional issues addressed in health education, these issues are central to understanding many women's needs and experiences.

Statement Of The Problem

The purpose of this study was to show the need for health educators to designate violence against women as a major health issue. It examined the fear of violence as a constraint to active lifestyles for females.

Factual Assumptions

The following factual assumptions guided this research:
1. The vast majority of abusers of women and children are men.
2. The violence done to women is real, is serious, is damaging to the point of life-threatening (Price 1989, p. 3).

Objectives Of The Study

This study was directed toward answering the following research questions:

a. What do mainstream health documents say about well-being and violence against women?

b. What are the implications of women's fear of violence to their participation in physical activity?

c. What are the individual strategies used by women in

order to participate in physical activity despite fears of violence?

d. What do feminist health materials say about well-being and violence against women?

e. What are the implications to women's well-being, as they participate in a physical activity, of not having violence against women included in mainstream materials?

Methodology

The methodology for this study included the following:

1. A textual analysis of three "representative" Health And Welfare Canada documents on women's health and well-being to discern what, if anything, was said about the context within which prescriptions for well-being for women were made. Specifically, the analysis focused on how violence, as an issue specific to women's health and well-being, was addressed in these materials.

The following Health And Welfare Canada documents were selected:

1986 - Issues And Priorities For Women's Health In Canada: A Key Informant Survey;

1986 - Achieving Health For All: A Framework For Health Promotion;

1990 - The Active Health Report On Women.

In an effort to construct as complete and detailed a picture as possible a systematic description of each document was

given followed by an assessment which focused specifically on how violence was addressed in the materials.

2. A focus group was conducted with five active female athletes in order to articulate some examples of women's experiences with the fear of violence in their participation in physical activity. A primary focus of the interview was to illustrate strategies used by women in order to participate in physical activity despite fears of violence.

i) Selection of the subjects:

The subjects in this study consisted of five active female athletes. Subjects were selected from among the women runners I know. I selected subjects based on their active involvement in physical activity and their willingness to provide anecdotal information concerning their individual strategies for safely participating in physical activity.

ii) Design of the focus group:

The design of the focus group was to serve a dual purpose. The first was to draw upon a wide range of personal experiences. The second was to allow individuals to respond in their own words which gave the subjects considerable latitude to express their experiences.

iii) Collection of the data:

After prospective subjects were selected, information was given about the project, agreement to participate was obtained and initial arrangements for the interview were made. Documents describing the research and obtaining informed consent were given out prior to the interview.

iv) Analysis of the data:

The taped interview was transcribed and quotations which shed insight into relevant aspects of the study were included in the final text.

3. A textual analysis to examine feminist health materials in order to delineate ways in which women provided holistic approaches to women's well-being and actively resisting cultures of violence.

Delimitations

1. Discussion in the focus group was delimited to violence committed by strangers.

Limitations

1. The conclusions of this study were limited by the documents selected from the World Health Organization.
2. This study was limited by the small sample of female athletes selected for the informal interview.

Organization Of Thesis

Chapter I - Introduction, including a description of the study, methodology and information on violence against women.

Chapter II - Textual analysis of three Health And Welfare Canada documents on women's health and well-being.

Chapter III - An examination of fear as a constraint to active lifestyles for women.

Chapter IV - Textual analysis of feminist health materials and a description of examples of feminist health promotion.

Chapter V - Conclusion and Implications.

Chapter II

TRADITIONAL HEALTH PROMOTION

Women's Status In Society

It is impossible to speak about the well-being of women without dealing with the current status of women. Despite a number of reforms, women are still not equal partners with men. In Canada, women, as a collective whole, continue to earn one-third less than men (McDougall 1989, p. 8) and a much lower value is assigned to the work women do. There are several other economic, social and legal issues that need to be addressed in order to narrow the gap between men and women. Most notably is under representation of women in the important areas of policy creation and direction. Without a strong public voice it is difficult to create changes to the patriarchal infrastructures of society. The issue of women's health must be broadened to include the political, economic and legal issues that prevent or limit women's achievement of their full potential. Using the old adage "the personal is political", it is necessary to reexamine the issues affecting the lives of women. Without creating a more just, egalitarian and humane society women will continue to be vulnerable to societal factors which complicate their daily struggle for well-being.

All women are faced with the issue of violence. Women are targeted for violence by men in two ways, sex violence and sexual violence. "It is sex violence, analogous to sex

discrimination, inasmuch as girls and women are targeted for violence precisely because they are female and therefore [thought to be] vulnerable and subordinate" (Price 1989, p. 78). It is sexual violence because it is "directed at women and girls in their sexual beings" (Price 1989, p. 78). These two categories of violence are manifested in several forms: domestic assault, dating violence, rape, sexual harassment, child abuse, elder abuse, pornography and prostitution (Price 1989, p. 5). These are only some of the various configurations of violence perpetrated by men, yet, they are all interconnected in that they form a distinct pattern of the power of males over females in society.

An undeniable link exists between how women are treated and their state of well-being. There is a need to outline the "injustice done to women, the profound contradictions with which they are forced to live, and the price they pay with their health" (McDougall 1989, p. 8). But women are making challenges and continue to be agents for social change. "And one thing is sure: by doing so, women can be certain of working for the well-being not only of their own health, but also that of their children and of men" (McDougall 1989, p. 8).

Health educators need to be responsible for the designation of violence against women as a major health issue by examining the underlying sexist bias inherent in society. There is a "widespread network of attitudes and social codes

that provide a firm foundation for the enactment of violence on women by men" (Price 1989, p. 90). One of the greatest obstacles to eliminating violence is its exclusion or token acknowledgement as a serious health problem. In order for change to occur it is necessary to "push at the boundaries of thought and action, boundaries imposed by men and ourselves" (Price 1989, p. 90).

This chapter examined three "representative" health documents to determine what, if anything, is said about the context within which prescriptions for well-being for women are made. Specifically, the focus was to examine how violence, as an issue specific to women's health and well-being, is addressed in these materials. The following three documents were selected from Health and Welfare Canada and are listed in chronological order:

1986 - Issues And Priorities For Women's Health In Canada: A Key Informant Survey;

1986 - Achieving Health For All: A Framework For Health Promotion;

1990 - The Active Health Report On Women.

Issues And Priorities For Women's Health In Canada: A Key Informant Survey

In 1983, the Health Promotion Directorate (HPD) of Health and Welfare Canada, formally identified women's health as a distinct program area. In 1984 the Women's Health Strategy

Project was developed. The purpose of this project was to prepare a strategy paper on women's health for the Directorate, and to recommend a long term program plan.

Issues And Priorities For Women's Health In Canada: A Key Informant Survey is a report that describes the findings of a 1986 survey of Canadian 'experts' on women's health.

> It is intended as a factual presentation of concerns related to women's health that were identified by the informants. The findings of the survey will be used in the future to develop policies and programs for women (Thomas 1986, p. 30).

The survey generated information in the following six areas: key health issues and problems for women; factors underlying women's health issues; important target groups; changes needed to improve women's health; priorities for the federal government; and existing health programs and activities for women.

The first segment of the report identified six key health issues for women. The key issues were: issues related to mental health; violence against women; reproductive health; reproductive disorders; nutrition and fitness; and chronic medical conditions.

In the second section, the report details the factors underlying women's health issues. The respondents were asked what factors and situations have the most serious impacts on women's physical and mental well-being (Thomas 1986, p. 10). There were five major responses: attitudes and practices of medical institutions; access to appropriate medical and health

services; women's roles and relationships; the economic status of women; and occupational and environmental conditions.

In the discussion of women's roles and relationships, what emerged as a concern, are the attitudes which undervalue women's traditional roles and employment. Concern was expressed regarding society's prescriptive expectations of women's role in the home, as well as the social isolation, economic dependence, and role conflicts that arise from them. The socialization of girls towards dependence and subordination and harmful attitudes and practices related to women's sexuality and women's bodies are also mentioned (Thomas 1986, 11). While these factors are relevant to a discussion of violence against women there is no attempt to link these specific problems to the issue of violence.

The third segment of the report focused on groups at special risk. "Informants were asked what groups of women in our society were particularly at risk for health problems, and what the key health issues and underlying factors were for them" (Thomas 1986, p. 13). Violence against women was identified as a special risk for immigrant and minority; native; and disabled women.

The last section of the report addressed changes and priorities that are necessary in order to improve the health and well-being of women. Respondents were asked:

> What changes were needed in programs, services, legislation, or any other areas to bring about

> improvements in the health and well being of women. They were also asked what they believed the priorities of the federal government should be for action on women's health (Thomas 1986, p. 18).

The respondents discussed needed changes and priorities in five different areas: health programs and projects; medical and health services; social and economic policy; health research; and regulations and legislation affecting women's health (Thomas 1986, p. 18).

Some examples of the recommendations are: the need for stable, long-term core funding for women's groups working on activities related to women's health, the development and support of a national women's health network, the involvement of women and women's groups in the planning of health programs and to support advocacy and lobby groups working for positive changes for women (Thomas 1986, p. 13).

Assessment of Issues And Priorities For Women's Health In Canada:

Violence against women, which was identified earlier as one of six key health issues for women, was not addressed as specifically relating to any of the underlying factors that negatively impacts women's health. In the discussion of women's roles and relationships the identified factors are relevant to a discussion of violence against women. For example, social isolation, economic and social dependence and harmful attitudes and practices related to women's sexuality and women's bodies are concerns related to violence against

women. Yet, there is no attempt to link these specific problems to the issue of violence.

The segment of the report that focused on groups at special risk identified violence as a special concern for immigrant and minority; native; and disabled women. It is accurate to indicate that violence is a major concern for these groups. However, it is problematic to only address violence as an issue that affects "vulnerable" groups. There is no mention of the incidence or impact of violence among women in general. Violence is a major health concern to all women and transcends all economic, ethnic, racial, geographic, ability, and age groups. Violence against women is an issue that must be addressed by all segments of society.

The information contained in the final section of the report, changes and priorities, is particularly important because it encourages women to identify areas of importance in health programs, such as key policy changes that guide health programs for women. This is an important step in eliminating barriers to women's health programs. However, there were only two recommendations dealing with violence. One, identified as a specific health and medical service need, recognized the need to improve medical services dealing with violence against women (Thomas 1986, p.20). The other recommendation was directed at regulations and legislation affecting women's health and called for an increase and strengthening of laws protecting women from assault (Thomas 1986, p. 58). Both of

these recommendations are important but they remain limited in their effectiveness. The areas of health programs and projects, social and economic policy, and research all have invaluable contributions to make towards addressing the issue of violence against women.

Violence was identified as a current major health concern related to women's health and well-being. Yet, the survey does not reflect this orientation. Issues And Priorities For Women's Health In Canada presents information that is difficult to reconcile. On the one hand, there is the identification of violence against women as an extensive health problem. On the other hand, the changes and priorities identified and directed towards women's health promotion does not adequately reflect this dilemma.

Achieving Health For All: Framework For Health Promotion

All of the research contained in Achieving Health For All and The Active Health Report On Women, reflect information collected in Canada's Health Promotion Survey. This was a telephone survey undertaken by the Health Promotion Directorate of Health and Welfare Canada and conducted on its behalf by Statistics Canada in June of 1985. The importance of the survey can not be overstated as subsequent health reports are concerned primarily with the presentation of the data gathered by the survey.

The 1985 Health Promotion Survey plays a key role in the

delivery of health promotion programs and health care services. The survey was the first national survey to "focus on health orientation and behaviour rather than health status" (Health And Welfare Canada 1987, p. 5). The purpose of the survey was to explore broad themes connected with health behaviours, attitudes and knowledge. The survey was very extensive in its range of topics because:

> its aim was not to probe individual topics in great depth, but rather to take a wide-angle view of the health orientation of Canadians and to gather the breadth of data that will allow us to explore the relationship among different aspects of health behaviour and the various factors that influence them (Health And Welfare Canada 1987, p. 5).

The 1985 survey was the major precursor of several detailed reports such as the Active Health Series of reports and several special studies on selected target groups and topics. Most importantly, the 1985 Health Promotion Survey, "provided health policy analysts and planners with data directly relevant to the Framework For Health Promotion" (Health And Welfare Canada 1993, p. 4).

Achieving Health For All: A Framework For Health Promotion presents an overview of the information generated in the 1985 Health Promotion Survey. The Framework For Health Promotion expands the definition of the term "health promotion" to:

> the process of enabling people to increase control over, and to improve, their health. It represents a mediating strategy between people and their environments, synthesizing personal choice and

> social responsibility in health to create a healthier future (Epp, 1986, p. 6).

This approach to health promotion puts forward the view that people's health is influenced by a broad range of factors. The recognition of the many contributing factors to one's health legitimized the need to develop health policies and practices within a broader context.

The Framework acknowledges that the health care system does not "deal adequately with the major health concerns of our time" (Epp, 1986, p. 4). The Framework clarifies that it will:

> examine in more detail the nature of the health challenges facing Canadians. For the purposes of this document, we shall confine our attention to those challenges deemed to be of national importance (Epp, 1986, p. 4).

The three challenges posed by the Framework are reducing inequalities, increasing prevention and enhancing people's capacity to cope.

A fourth section deals with implementation strategies or processes which direct the action in response to the health challenges. The three strategies are fostering public participation, strengthening community health services, and coordinating healthy public policy.

Assessment of Achieving Health For All: Framework For Health Promotion:

Although the Framework states that health is a "basic and dynamic force in our daily lives, influenced by our

circumstances, our beliefs, our culture and our social, economic and physical environments" (Epp 1986, p. 3), the emphasis it places on individual behaviour minimizes the understanding that people's health is influenced by a broad range of social factors, such as the social and physical environments in which people live. Health cannot be measured strictly in terms of individual strategies and behaviours. While in the inequalities section, inequalities refers to the health of low- versus high-income groups in Canada, discussion is limited to economic status as a leading health challenge:

> The first challenge we face is to find ways of reducing inequalities in the health of low- versus high-income groups in Canada. There is disturbing evidence which shows that despite Canada's superior health services system, peoples health remains directly related to their economic status (Epp 1986, p. 4).

The increasing prevention section identifies the factors which cause a condition in order to reduce or eliminate them (Epp 1986, p. 4). The prevention efforts discussed here are directed towards the area of individual lifestyle and behaviour. Attention is focused towards eliminating risk behaviours such as smoking, alcohol consumption and high fat diets by changing people's lifestyles:

> The realization that smoking, alcohol consumption and high-fat diets were contributing variously to lung cancer, cirrhosis of the liver, cardiovascular disease and motor vehicle accidents, led us to turn our attention to reducing risk behaviour and trying to change people's lifestyles (Epp 1986, p. 5).

The enhancing coping section is directed at improving

people's ability to manage and cope with chronic conditions, disabilities and mental health problems. Discussion in this section is focused on a variety of conditions that "limit people's capacity to work, to take care of themselves, to perform the activities of daily living and to enjoy life" (Epp 1986, p. 5). Mental health is highlighted as an area of particular importance, especially for women:

> Women are more vulnerable in this regard. The fact that women are prescribed tranquilizers and anti-depressants more than twice as often as men is a telling sign of the emotional strain women are experiencing. For some, it may be the changing and uncertain nature of their role that is unduly stressful. Others may be overwhelmed by the burden of caring for family members, particularly those who are chronically ill or disabled. (Epp 1986, p. 5).

The Framework indicates that mental health is a priority. In its short discussion of women and mental health the following discriptors are used: vulnerable, emotional strain, unduly stressful, and overwhelmed. However, the following segment, which addresses men's mental health has a decisively different tone:

> The changing nature of social roles and factors such as unemployment have also had a bearing on the emotional well-being of men, who may encounter health problems including ulcers, dependence on alcohol and depression (Epp 1986, p. 5).

The Framework implies that women find their lives stressful and need to learn coping mechanisms. Yet, the Framework fails to account for the societal factors that directly effect women's mental well-being. The Framework states that mental stress can "find expression in many forms,

including child abuse, family violence, drug and alcohol misuse and suicide" (Epp 1986, p. 5). There are a number of problems with the above information. First, this is the only time that violence is addressed within the Framework. Nowhere within the Framework is violence against women cited as a national health challenge or problem. Violence, and its enormous impact on people's well-being, is not adequately addressed as a major health concern of our time. The Framework fails to provide an approach that will access the influence of violence on the general level of well-being. There are enough statistics on violence and misogyny to document the various influences that violence has contributed by affecting the nature and incidence of women's health and well-being.

Second, there is no excuse for putting the problem of violence aside. The problem does not disappear because of difficulties fitting it nicely into a conceptual framework.

Third, mental health is defined as:

> the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities, the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (Epp 1986, p. 5).

Using this definition of mental health it becomes impossible to deal with issues of women's mental health by focusing on enhancing women's capacity to cope. Unless violence against women is viewed as more than a "problem associated with mental

stress" (Epp 1986, p. 5) attempts to improve women's mental health will remain functionally useless.

> Battered women are over represented among female alcoholics, drug abusers and women who have mental illness. Suicide is twelve times as likely to have been attempted by a women who is subject to abuse than by one who has not (United Nations 1989, p.21).

With this type of information available to health professionals it is unreasonable that violence is not addressed in all health documents.

Another key component of the Framework are the three health promotion mechanisms. These are:

- self care, or the decisions and actions individuals take in the interest of their own health;
- mutual aid, or the actions people take to help each other cope; and
- healthy environments, or the creation of conditions and surroundings conducive to health (Epp 1986, p. 7).

Clearly, all of these mechanisms are intrinsic to health promotion. However, as stated in the Framework, the creation of healthy environments is "by far the most complex and the most difficult of the three mechanisms or kind of action required for the promotion of health" (Epp 1986, p. 9). Yet, for women this is the response that is needed to address the issue of violence. By focusing on mechanisms such as self-care and mutual aid and by continuing to ignore the deeper

roots of violence against women, we perpetuate the very environment which influences women adversely in the first place. As stated in the conclusion of the Framework, "we cannot invite people to assume responsibility for their health and then turn around and fault them for illnesses and disabilities which are the outcome of wider social and economic circumstances" (Epp 1986, p. 12).

Among the strategies the fostering public participation sub-section involves encouraging people to assert control over the factors which affect their health. This approach generally follows a self-help model to encourage participants to preserve or improve their own health. The Framework states that:

> Health promotion means ensuring that Canadians are able to act in ways that improve their own health. ...Our experience confirms that people understand and are interested in the circumstances and events that influence their health. We know that they are seeking opportunities to take responsibility (Epp 1986, p. 6).

Strengthening community health services is also stressed as a key strategy in the Framework. This approach increases the involvement and responsibility of community-based health services. The assumption is that there will be a greater emphasis on providing services to groups that are disadvantaged (Epp 1986, p. 10). Both of these strategies, strengthening community health services and fostering public participation, have severe limitations to addressing the issue of violence against women. Generally, these strategies have

focused on people to the exclusion of societal causes. Public participation, such as the establishment of shelters and safehomes for women and children who are experiencing violence, treat only the women and not the violent men or the society which tolerates such violence.

The third strategy, coordinating healthy public policy, is crucial in the efforts to address the issue of violence against women. Health policies set the stage for health promotion (Epp 1986, p. 10). As stated within the Framework, policies which have a direct bearing on health need to be coordinated, "The list is long and includes, among others, income security, employment, education, ... justice and technology" (Epp 1986, p. 10). Coordinating policies among these sectors will be difficult. Difficult - but not impossible. For example, there has been a large inter-governmental effort at the provincial and federal levels on the issue of drunk driving. Some of these efforts include "amending the criminal code, improving road safety, making police enforcement more efficient and controlling the availability of alcohol (Epp 1986, p. 11). Such a multi-dimensional campaign to end violence against women would be a significant step.

Public policy must become coordinated in order to respond to the issue of violence. Violence against women must have a level of categorical importance equal to that of other health concerns. For example, we need to provide a legal context in

which women are protected from violence. Judgements have to be made by society in respect of the values it holds, and by governments in respect of the funds that are allocated to the preservation of women's health.

The Active Health Report On Women

The Active Health Report On Women is one of a series of interpretive reports based on Canada's Health Promotion Survey. It is one of two reports that deals with specific population groups. The report is developed in the context of the health promotion model, Achieving Health For All: A Framework For Health Promotion. The aim of the report is to "raise and answer questions, and to stimulate discussion about how we can best enable members of each group to attain their personal aspirations for health" (1990, p. 3). The survey reported "the health knowledge, attitudes, beliefs and practices" of Canadian women. The survey focused on such issues as income, education, and employment and their relationship to health. The survey asked selected women to rate their own health, stress, happiness and degree of physical activity. The basic aim of this project was to enable women to take control of those things which determine their health.

Assessment of the Active Health Report On Women:

The survey from the Active Health Report On Women is, by

its own admission, significantly limited. "Certainly very important topics, such as dental health, family responsibilities, sexuality, violence,... were excluded" (p. 4). The fact that these topics were excluded from the survey demonstrates how issues specific to women's health are not addressed. Until violence against women is examined by health and well-being agencies, such as Health and Welfare Canada, research like The Active Health Report On Women will be inaccurate and inadequate.

A problem with this report is that the approach to women's health is directed at the individual level. "The almost exclusive focus on personal attributes in public health has brought about the 'lifestyle approach to health policy'" (McKinley 1992, p. 11). A major fault of this approach is the narrow focus on the individual. The result is that negative social factors are left out of the health promotion picture and there is no accounting for any external agents that help to shape women's daily experiences. This approach to health promotion is impractical in the context of a social system in which behaviours are culturally generated and maintained (McKinley 1992, p. 12). In our society male violence directed at women is encouraged through a variety of social forms. Directing public health interventions at the individual level is problematic as this method does not address the social controls that produce and reproduce relations of dominance and subordination between men and women.

Researcher John McKinley believes that planned sociopolitical change is the most effective mechanism for health promotion. In McKinley's article "Health Promotion Through Health Public Policy: The Contribution Of Complimentary Research Methods", he states "Although efforts to modify at risk behaviours are clearly important, they represent only one side of the coin. On the other side lies the contributions of aspects of the broader social system" (1992, p. 12).

The first chapter of the Active Health Report On Women is entitled "How Women In Canada Rate Their Health", and investigates the relationship between women's self rated health, happiness and activity-limiting health problems. The intention of this chapter is to "put health in the context of the everyday living conditions of women" (1990, p. 3). The respondents were asked "In general, compared to other persons your age, would you say your health is excellent, very good, good, fair or poor?' An overwhelming majority (87%) of the women surveyed reported that their health was good, very good, or excellent for their age (1990, p. 5). However, this information conflicts with other data on women's health:

> ...we know that women report more health problems and are more frequent users of health services than are men. According to the 1981 Canada Health Survey, for example, of all the health problems affecting Canadians, 60% were reported by women and women averaged more than twice as many major activity-loss days as men (1990, p. 7).

The report uses the results of women's self-rated health and

projects these as an accurate measure of women's health status. This is unrealistic as the report fails to solicit information on life circumstances, such as violence, which is reported to affect many women. The report should inquire about women's personal safety as freedom from violence is an important determinant of how women rate their own level of health.

The third chapter, "Increasing Prevention", states that "women are in the vanguard of healthy living...but, there is considerable room for improvement" (1990, p. 14). Yet, the only areas where improvements are suggested are in areas of personal health practices such as alcohol, tobacco and drug use, nutrition, exercise, seatbelt use and others. There is no discussion which includes the social and environmental influences which impact women's health. The Canadian Framework for health promotion and policy development is supposed to be committed to increasing prevention both at the individual and the community level, yet, the focus is overwhelmingly directed at the individual. For example the report states that "nonetheless, there is room for improvement in a number of women's prevention practices and attitudes" (1990, p. 21).

The chapter closes with the following sentence:

> The focus of this survey on discretionary health practices is not meant to imply that they are always the result of free and informed choices; "blaming the victim" for poor health practices is neither justified nor effective in promoting behaviour change" (1990, p. 21).

The above statement encapsulates the focus of the Active Health Report On Women. The report is aimed at promoting behaviour change in women in order to promote health. However, it fails to respond to the external factors, such as violence which influence many Canadian women's health and well-being. The report fails to address health promotion efforts beyond individual women. The community, the family and the social environment within which women live have been virtually ignored. In order to meet the goal of enabling all women in Canada to achieve optimal health, there has to be an exploration of women's health in a broader context.

Summary

Violence has a serious impact on women's physical and mental well-being. However, mainstream health documents do not adequately address violence as a concern relating to women's health. The focus on individual-level determinants of health and the lack of a systematic analysis of wider social, political and economic processes means that an understanding of the impact of violence is limited.

Health documents need to be analyzed in terms of the extent to which they might reinforce or challenge wider social structures. There is no exploration, for example, of the absence of violence against women in health documents and the extent to which this absence might reinforce or challenge the dominant view that there is not widespread violence against

women. Moreover, given the narrow focus on women's health, male violence is not treated as problematic, rather it is women's health (or lack of health) which is defined as problematic and men's violent behaviour is not perceived as being implicated in this pattern.

CHAPTER III

THE PARADOX OF PHYSICAL ACTIVITY FOR WOMEN - FEAR AS A CONSTRAINT TO ACTIVE LIFESTYLES FOR FEMALES

It is generally well known that exercise has a somatopsychic effect. The association between well-being and exercise is based on a wealth of anecdotal evidence dating back to the Greek ideal of sound body, sound mind. People who regularly engage in physical activity claim that they experience improved self-image, a relief of tension and that they feel stronger, happier and more energetic. Physical activity is a means to an end - enhanced health and well-being. Yet, for many women, participating in physical activity might paradoxically put them at risk of an unprovoked attack. It is ironic that the very means by which women can improve their well-being is potentially an area where women experience fear and/or violence.

Many women desire independent leisure outside of the home but experience tremendous fear and anxiety over their safety. In reality, most women are extremely restricted in their opportunities for leisure. According to Henderson and Bialeschki's article "Fear As A Constraint To Active Lifestyles For Females", "Fear for one's physical and psychological safety is a common restraint to physically active lifestyles for women and girls" (1993, p. 44). This fear is manifested into many forms, "ranging from the elimination of physical activity to the great planning that

must be undertaken to cope with and overcome fear for one's safety" (1993, p. 44). The following section is devoted to exploring the "social processes through which women's access to leisure is constructed, defined, and regulated" (Green and Woodward 1988, p. 144).

Physical activity is recognized as contributing to one's pleasure and enjoyment, yet, many women never experience a sense of freedom in an activity. Many women fear not only physical harm but also psychological harm. Clawson and Knetsch outline the five phases involved in any recreational experience: anticipation, travel to, the actual activity, travel from, and recollection" (Green and Woodward 1988, p. 144). Fear can be a factor in any phase of the experience (Green and Woodward 1988, p. 45). These experiences affect women's attitudes about leisure, themselves and their bodies. Females learn that they must not be out alone thus eliminating some physical activities solely for this reason. Females often rely on partners and must attempt to coordinate their time and activities. Travel to and from activities may also be a site of anxiety. For example, if a woman feels unsafe walking or driving at night she may be discouraged from engaging in a leisure pursuit. In the recollection phase, if a frightening experience is associated with the recollection of a past activity, then the memory of this experience may prevent or reduce the likelihood of the individual participating in the future. Henderson and Bialeschki explain

the dilemma in clear terms:

> The upshot of the problem is that many females do not have opportunities for physical activity. Walking, jogging, running, participation in organized sports activities that require travel away from home, particularly in the evening, or access to any activities such as camping or hiking may put females in a vulnerable position, in which they might experience fear and violence (1993, p. 45).

Fear is a social control mechanism that powerfully constrains women's leisure. The problem that arises is that this fear is naturalized as women experience the world and negotiate their safety by altering or withdrawing from physical activity. Green and Woodward explains in their essay " 'Not Tonight, Dear!' The Social Control of Women's Leisure" that:

> Prevailing ideologies about appropriate behaviour are enforced through social control mechanisms ranging from verbal hostility, ridicule and unwanted comments with sexual connotations, through to the threat or actual use of physical violence against women" (1988, p. 144).

It is widely accepted as 'normal' that women must operate with limited freedom for their own 'protection'. The problem does not belong to individual females. "A considerable body of evidence points to the fact that both the regulation of women's access to public places and their behaviour once they gain entry, are grounded in the question of women's right to occupy particular spaces" (Green and Woodward 1988, p. 134).

Expectations about women's roles are deeply entrenched within the social fabric and accepted as 'normal'. "Women as

a whole experience circumscriptions on their freedom of movement because of their fears of encountering male hostility in leisure venues or on the streets" (Green and Woodward 1988, p. 144). By promoting that women use "avoidance strategies to minimize the likelihood of sexual harassment or other forms of interpersonal violence" (Green and Woodward 1988, p. 138), women are still denied the right to independent leisure. The use of 'coping strategies' serves to reinforce the status-quo which protects male leisure and limits women's.

Fear is a powerful constraint to active lifestyles for women. This fear directly limits the types of activities women choose to become involved in. Henderson and Bialeschki note that:

> Leading an active physical lifestyle, whether a daily aerobic routine such as running or walking or having access to outdoor adventures, should be the right of every individual, not an opportunity that must be negotiated carefully each time; females should not feel penalized for engaging in active lifestyles (1993, p. 47).

Women who run/jog also face a dilemma, as it is very difficult to run on a regular basis and remain perfectly safe. Women runners are familiar with a spectrum of abuse ranging from murder and rape on one end to annoying comments, heckling or harassment on the other (Nelson 1991, p. 121). These incidents occur in the daylight as well as at night. In order to minimize the occurrence of interpersonal violence, women are encouraged to be very particular about their running habits. It is not safe for women to run alone, yet, it is an

unrealistic expectation for women to be able to find an available running companion for each run. Some of the suggested guidelines for women are streetwise but also often unrealistic. For example, women are encouraged to vary routes and times of runs, while always running in familiar areas and informing others of their routes. Other strategies include staying away from doorways, brushes, running clear of parked cars, while altogether avoiding isolated trails (Nelson 1991, p. 121 and The Running Room [Appendix B]). Also, these suggestions eliminate the use of bike paths as a recreational option for women.

Ideally, running provides an individual with a sense of freedom. Mariah Burton Nelson writes in an essay called "Running Scared" how running, an activity that usually relaxes the mind and muscles, can make women tense and hypervigilant: "It is a paradox, exclusively female: the stronger a runner gets the more likely she will be to assert herself, venturing into a world where she will be rudely reminded of her fragility" (Nelson 1991, p. 122). Even when women are directly pursuing an increase in health benefits through physical activity, there is no escape from the reality of fear and violence in women's lives.

Unfortunately, when a women in our culture experiences violence while engaging in physical activity or at any other time, there is a tendency to hold her responsible for the occurrence. Often females are blamed or held partly

responsible for the male violence they encounter. Victim blaming redirects responsibility away from the aggressor and reduces the accountability of society in general. Women are raised in a social system which allows and excuses men's violent actions. Therefore, any effective health promotion policy must not solely focus on women's individual lifestyles but must primarily be focused at our social system, which allows women to be terrorized by male aggression.

It is essential that fear and violence are recognized as constraints to active lifestyles for females. This acknowledgement will remove the tendency in the individual lifestyle approach to blame the victim. It is important to note that despite the ubiquity of harassment women continue to be involved in physical activity in large numbers. One could only estimate women's participation rates in a society where women were valued as much as men. Women continue to struggle to improve the quality of their lives. However, for this goal to be realized there needs to be radical social change.

FOCUS GROUP:

Violence against women in physical activity is a misunderstood dimension in women's lives. Fear and issues of violence against women as a constraint to physical activity have not been highly visible topics within mainstream sport literature, thus, women participating in physical activity are treated within limited contexts. By conducting a focus group

using five active female runners, a discussion was initiated in which women articulated some examples of their experiences with fear and/or violence in their participation in physical activity. The purpose of this investigation was not to establish the frequency of such experiences, but rather to let women's accounts be heard. A primary focus of the interview was to illustrate strategies used by women in order to participate in physical activity despite fears of violence.

1. What emerged from the interview was that the desire to run alone was paramount as was the constraint - fear. Dissonance clearly existed between what the women preferred, in terms of running alone, and the reality of their lives. All the women agreed that running provided them with many benefits including enjoyment and a contribution to mental well-being. Yet, for some women running alone caused anxiety over their personal safety:

> Subject #1: My fears are around that I will be attacked or somehow physically hurt when I'm out if I'm by myself. ...I used to run by myself and I used to do it to have what was called a 'mental health run', where I just ran and it would be really stress relieving being down in the woods and banks, it would be nice going up and down hills like that, but now if I go I run but I'm always looking behind me and its not the stress reliever that it used to be.

> Subject #3: While I definitely do (have fears). I would never run at night by myself. ...and I watch what time I go - if its during school days, like when people are at work I would run down in the country while people are at work, because I wouldn't want to when the roads are busier. That's the only time I would do it. I'm very careful about when I go running.

> Subject #5: ...there's even times in the day when I don't feel safe in the river valley, but I don't think it stops me from going.

However, not all of the women experienced fear:

> Subject #2: I have absolutely no fear of running by myself at all. I just go and do it and it doesn't matter if its daytime or nighttime...

> Subject #4: When I run I do it more as a mental break and I prefer to be alone and away from people or vehicles or anything... so I run in the river valley and I don't have any fears that would stop me from running at a certain time or anything like that.

2. The following is a brief outline of the range of experiences that the women reported in the interview. It is important to detail some of the incidents in order to establish the range of violence directed at women. By doing so, I hope to give the reader a direct and immediate sense of the kind of events which constitute violence. The women experienced behaviours that ranged from leering to verbal harassment to actual physical contact. The events are commonplace in the sense that they are not out of the ordinary. That does not make them any less disturbing.

> Subject #1: The only time I have been physically punched by a male was when I was running. ...it was during rush hour traffic and lots of people on the street and everything and this fellow...was just walking on the street towards me and I was running and he punched me in the breast and I got really angry, but I kept going.

> Another time in the early morning, it was about 5:00 or 5:30 something like that, and these guys had come by in a car and they were totally pissed and gaggling out the side of the window and stuff like that. And I got sort of scared and I switched to the other side of the road and they drove past

and then they stopped and backed up and I got really scared. I ran into the ditch and they did nothing, they didn't come out of the car or anything but I just got really scared and I just started to scream and I screamed and screamed and screamed. And they started to laugh and just drove on.

Subject #3: I got myself a german shepherd now since I had that incident. It happened in the winter... I was out running and some guys stopped their truck just up ahead and I was running along and I thought O.K. and they got out and put something down on the road and then they got back into the truck and they drove off. So I got to this thing that was on the road and it was a really disgusting pornographic magazine and it was opened to a really gross picture of a woman and it said "Fuck You" written across it, you know, and I still had two miles to go right through the country and there are no houses in between...It was just scary and I thought well I'm getting myself a dog, I've had enough of this.

Subject #5: I like to run in an area that is away from the street because I'm pretty self-conscience, so running and getting comments thrown at me is disturbing, because that has happened to me because I'm rather large chested for a runner so I get that sort of comment. And I find that really quite threatening, so I prefer to run where I can't really be seen or around other runners or people doing activities.

In the incidents described above, women are attacked at the level of sexuality. They are either treated as the objects of male fantasy or as the potential targets of sexual violence. These events are merely a sampling. Events such as those described above are relatively common and their occurrence is generally unquestioned.

It is important to note that not all of the women reported incidents. However, all of the women were quite aware of the dilemma that faced women runners. The women that

did not experience any behaviour that they felt was threatening were still conscience of other women's fears of attack:

> Subject #4: Fear does not minimize my participation in physical activity but I know that it does for other women for sure. ...I know that there are some women who would like to run but are scared to run at night so they find an alternate sort of activity, whether it be aerobics or rollerblading or whatever with a group of friends. But, if they want to run and then are scared to, unfortunately they find something else, but fortunately, they are still doing something.

3. Despite the fear of violence female athletes have persisted and succeeded in remaining actively involved in physical activity. The following segment illustrates the strategies that the women employed in order to continue running despite fears of violence.

> Subject #4: I know that one of my friends would run with this little thing of caesium, like bear spray, and she would feel totally comfortable if she has that...
>
> Subject #1: I still do most of my running on my own. I'll stay up on top of the street and stuff like that, as opposed to running in the river valley. I'll run in the river valley with a group or at least one other person.
>
> Subject #4: Even though this takes away form the individual aspect of the sport, just running with one other person multiplies your safety by ten fold.
>
> Subject #1: I'm a lot more careful about when I run now. I used to go really early in the mornings before 6ish and be home by 7:00 and not feel scared at all, but I don't do that now. I would run, I guess the earliest I would run would be at about 6:30. I actually like to run in the evening but I don't think I would go out any later than 10:00.

> Subject #3: I got a dog specifically for running. ...The question that people ask me is - well, what are you doing running out in the country. That really bugs me. I have a right to run out in that country. I used to run with a golden retriever before and they're not very fierce dogs, but I found that kept a lot of the comments down.
>
> Subject #4: I get so frustrated when I hear of something like that happening and people not running at certain times or not wanting to wear a bra top to run in, just because you might get cat calls or whatever, it's just irritating. It really angers me when I think that we can't run in the river valley because incidents have happened. So I almost have this take-back-the-night attitude, where I'm gonna run.

The above comments detail some individual strategies that the women employed in order to participate in physical activity. It is disturbing that women must take such measures to increase their personal safety. As explained earlier in the chapter, when women runners follow a series of do's and don'ts (don't run at night, don't run alone, do run in populated areas) a dilemma exists as these strategies severely limit women's freedom and shift the responsibility and blame from the offender onto women.

Summary

Leading an active physical lifestyle should be the right of every individual. Yet, fear is a powerful constraint to active lifestyles for women. It is disturbing that even when directly pursuing an increase in health benefits through physical activity that many women encounter fear and violence.

However, it should be celebrated that despite the

frustrations, fears, dilemmas and barriers facing women, that many women still regularly participate in physical activity. Women have a strong collective will that enables them to fashion positive meanings from their athletic experience. It is now the responsibility of health and physical educators to ensure that women can participate in non-threatening, safe environments. Physical activity is an important component in women's struggle for well-being.

CHAPTER IV

FEMINIST HEALTH PROMOTION: WORKING AGAINST VIOLENCE AGAINST WOMEN

Introduction

"The women's health movement has been one of the most visible and best received aspects of the women's movement" (Whatley and Worcester 1989, p. 199). Since the late 1960s, groups of feminists throughout the world have critiqued traditional health systems that are based on the values of the male medical establishment. The intent of this chapter was to characterize the women's health movement and to describe examples of feminist health promotion in order to delineate ways in which women are providing holistic approaches to women's well-being and actively resisting cultures of violence.

The contemporary public health model calls for the active participation of the public in health promotion efforts. A problem with this approach is the almost exclusive emphasis on the individual and the individual's responsibility for correcting an 'unhealthy' lifestyle. Such a narrow focus on the individual presents a serious problem for women in their struggle to achieve health and wellness. The limitations of traditional health promotion arise largely form a failure to locate the area of women's health within a wider social, political and economic context. The lives of women and general health policies are treated as two distinct spheres

with no analysis of the underlying processes which structure the two and which structure the relationship between them.

Nationally and internationally, there has been increasing recognition that health professionals need to address specific women's health issues and that health promotion requires more effective directives aimed at improving the health situation of women (Smyke 1991, p. 59). A major obstacle that many women face in their daily struggle for well-being is violence. The climate of violence directed at women is global and exists in many forms, so much so that violence against women is the leading cause of death of women internationally (Bunch, 1991). Many women define violence against women as the number one health issue facing North American women today (Whatley and Worchester 1988, p. 197).

Designing and implementing comprehensive strategies for addressing violence against women involves both the thoughtful translation of the base that supports modern public health and the active participation and appropriate actions by the public. Examining health risks for women has led to an important conclusion that, in addition to traditional health promotion methods available to use, "effective prevention and health promotion strategies increasingly depend upon appropriate social and behavioral solutions to the problem" (Kar 1989, p. ix). Therefore, any initiatives concerning the determinants of health must take into account the social, political and economic framework of society. Yet, as examined

in chapter three, traditional health documents poorly respond to socially related health problems resulting in women's health documents that are technical and apolitical, and which have a specific set of relatively narrow aims.

What is the women's health movement? The women's health movement is an extraordinary social movement that is based on the idea that women should have the right to control their own bodies. This movement was born in the United States in "a half-dozen cities during the late 1960s" (Dreifus 1977, p. xxv). "Radical, anarchic, sometimes leaderless, sometimes not, the women's health movement cannot be defined as one set thing" (Dreifus 1977, p. xxiv). The scope of the movement is enormous as "hundreds of groups together constitute what we are defining as the women's health movement"(HealthRight Collective 1977, p. 14). The women's health movement has recognized the limitations of this individualistic approach to health and has recognized the wider social, political and economic causes of women's ill health.

Feminist Health Promotion

Feminist health promotion has a central role in improving the standards of health and well-being for women. Traditional health promotion is grounded in an analysis that does not accurately reflect women's needs and experiences. The effect has been to deny/overlook the problem of violence against women and define women's health in largely familiar,

comfortable and safe ways. Feminist health promotion is sensitive to the differences and diversity that characterizes women's lives and experiences.

A feminist orientation illuminates biases in research and practice and identifies research concerns and methodologies that are important to women. According to feminist researcher Margrit Eichler, feminist writing and research serves three functions:

> is critical of existent social structures and ways to perceive them, it serves as a corrective mechanism by providing an alternative viewpoint and data to substantiate it, and it starts to lay the ground work for a transformation of social science and society (Eichler 1980, p. 9).

What feminist philosophy offers health education is a more responsive health promotion, "and it means working toward a world where gender does not predict one's ability to be healthy, active and well" (Mellow 1989, p. 393).

Feminist health promotion is premised on a recognition that a healthy lifestyle is not just a matter of individual choice. Feminist health promotion concerns itself with all societal actions affecting the health of women, including the public, and identifies those actions that can be promoted through organized, feminist based health promotion programs. As Black and Ong state in their writing on women and health courses:

> ...we ask questions about why women become ill. We make connections between women's roles in society (carer, worker, mother, wife, and so on) and patterns of health and illness among women. Thus, we hope to break away from individualistic

explanations of ill-health (1986, p. 23).

A feminist approach involves a focus on women and an open belief that women suffer from structural inequalities in society. This requires a "recognition of the lives of women in political terms and suggesting solutions to what are often seen as individual problems" (Orr 1986, p. 70).

A central aim of feminist health promotion is to provide a greater understanding of what contributes to well-being, and to facilitate the identification of courses of action that must be taken to improve health. A feminist perspective is a powerful tool for analyzing health problems. Feminist health promotion provides a new perspective on health, a perspective that encourages the recognition and exploration of hitherto neglected areas. One of the main advantages to feminist health promotion is its balanced approach to health. A comprehensive analysis ensures that all aspects of health will be given due consideration. All the fragmented areas of health are brought together into a unified whole which permits health educators to see the importance of a wider range of factors.

An important distinction to be made is that a feminist approach to health promotion requires a philosophical and a moral response rather than a purely intellectual one. Feminist health promotion is concerned with health, not so much in a crudely functional sense, but as a necessary condition of life. Feminist health promotion recognizes that

health is a human right much like social justice (Arnold 1991, p. 105).

Feminist health promotion contains a range of feminist perspectives, yet, there are certain commonalities of approach. First of these is a more holistic view of health. Health includes physical, mental and emotional well-being "and as such particularly includes being active and empowered" (Ratcliff 1989, p. 4).

Through a feminist lens health becomes multifacted rather than one dimensional. Feminist health promotion is relational in that there is a recognition of the need for fundamental changes in both health provision and women's role in society and as such requires a holistic approach to health weaving the social, cultural, political, and economic into a single fabric that constitutes women's well-being. Therefore, any research into the health of women must address women at the individual, family, group, organizational, institutional and national level.

Second, feminist health promotion is grounded in women's experiences and adopts a woman-centered perspective. Putting women's experiences at the center allows feminists to recreate/reshape traditional approaches to women's health. This approach allows women to "define health and illness from the perspective of women's own experiences" (Black and Ong 1986, p. 23). By basing health promotion on women's lived experience women are empowered as knowledge is shared and

developed. Black and Ong state that:

> Our society individualises people and, by cutting them off from each other, makes them powerless. By sharing, we can go beyond individual experiences, begin to see the more general patterns of health and illness, and relate these to women's roles in society and to how we are oppressed by being kept ignorant as a group. ...This differs from the kind of health education which puts the emphasis on individual responsibility for correcting an 'unhealthy' lifestyle (1986, p. 23).

Traditionally, women's health concerns have been falsely universalized as there has been little understanding of the complexities of women's lives. Flora, Jackson and Maccoby explain that in mainstream health promotion the following contradiction exists:

> Although the need for a comprehensive approach to health promotion is recognized, it has rarely been acted upon. Rather, the majority of theoretical and applied work in health promotion has been restricted to individual behaviours, particularly behaviours associated with health services utilization and risk factor modification (1989, p. 119).

A feminist approach to health recognizes that there are a wide and complex range of health concerns. Feminist health educators search for societal-level determinants of health as well as the individual-level variables. This approach gives a central place to issues of male violence as a constraint to women's health.

Third, feminists associated with health promotion have begun the task of pointing to problems with current conceptualizations of dealing with the situation of women's health, and of proposing new concepts and solutions. A

feminist analysis alerts us to the identification of inappropriate assumptions which underlie the current conception of health and health projects. The most glaring assumption in traditional health promotion is the "lifestyle approach to health policy" (McKinley 1992, p. 11) which ignores the underlying factors that negatively impact women's health. A feminist approach provides a vital new analytical tool that demands not only a new approach to women's health but also to the "facts" (i.e., research, social and economic policies)on which knowledge is based.

Fourth, feminist health promotion does more than deconstruct and articulate the oppressive formations that exist in health promotion. Feminists are developing practices that enable women to challenge and change the oppression in their lives. The traditional boundaries of health promotion do not encompass political action and advocacy whereas feminist health promotion develops comprehensive strategies and then follows the political course necessary to implement those strategies.

An overview of women's health projects indicate a broad variety of types of projects: information generating projects (i.e., providing health information or women's rights information); change-oriented projects (i.e., fighting for improved legislation); income generating projects and service orientated projects (i.e., shelters). The most fundamental and underlying principle of feminist health promotion is that

of structural transformation, a notion that challenges the economic, political, and cultural forms of domination.

> Aspects of our culture which discriminate, restrict and devalue women's physical, psychological and political development must be eliminated. To achieve this women must be mobilized politically for action... (Christiansen-Ruffman 1987, p. 6).

The problem of violence against women is complex and multifacted and thus requires solutions that are similarly complex and multifacted. Political action and public advocacy are needed.

A feminist approach to health promotion includes both the experiences of women, whose health is advocated, and the definition of health. How then does a feminist approach to health promotion help to address the issue of violence against women? First, and perhaps most important, it enables us to be aware of the extent of the problem and therefore makes us recognize it as a legitimate health concern. Feminist health promotion documents a need for responding to the pattern of leading health threats through better social and behavioral interventions. As Snehendu Kar explains:

> In simple fact, the leading cause of death and disability are now those for which we lack effective medical or clinical solutions. ...There are no antibodies, vaccines, or miracle drugs to prevent the current leading causes of death and disability. The etiologies of these and other leading causes of death and disability are deeply embedded in our social, environmental and behavioral systems (1989, p. x).

Therefore, prevention of violence against women as a health problem "depends upon the extent to which programs can

stimulate and appropriate individual and societal action" (Kar 1989, p. x). Solutions to this problem are beyond the scope of the traditional health approach. Instead it requires a feminist approach to health which emphasises political action and public advocacy.

Examples Of Feminist Health Promotion

Feminist health promotion is based in a "framework that recognizes the dynamic interplay of many factors and extends our understanding of health beyond a traditional focus on the health care system" (Ontario 1991, p. 20). A recognition of the need for fundamental changes in both health promotion and women's roles in society are central to the analysis and work of the women's health movement. Activists have had a dramatic impact on the general awareness and knowledge about women's health issues. This section looks at actions that have been taken to improve women's health. Specifically, these examples explore how women have directed their collective anger into many kinds of actions opposing violence against women. Violence against women "can only be prevented by responsible individuals and organized societal actions" (Kar 1989, p. 4). This constitutes only one example of justifying the importance of a feminist health approach.

The examples provided in this chapter are not intended to present a complete and exhaustive description of examples of feminist health promotion. It is based on the work of several

women's groups who employ less-than-conventional forms of health advocacy and demonstrate the "creative ways in which women fight for themselves, their children, their families, and indeed, the planet" (Mellow 1989, p. 371).

Healthsharing: A Canadian Women's Health Quarterly

Healthsharing: A Canadian Women's Health Quarterly was a Canadian, feminist-based magazine that addressed women's health issues. Healthsharing was in circulation from 1979-1993 and "attempted to reflect the radical roots of feminist health activism, broaden the concept of health and include a more global representation of women's voices" (Gottlieb 1993, p. 4). Healthsharing attempted to re-direct women's health care away from its traditionally narrow focus on women's individual behaviour by examining women's health issues at a broader level.

Healthsharing adopted a holistic approach to women's health. Healthsharing editor Amy Gottlieb explained:

> feminist health activism is about looking at women's lives as a whole, about the impact of women's oppression, poverty, racism, class bias, abilism, ageism on our lives - it's about making fundamental changes to our medical system (1993, p. 4).

Healthsharing encouraged women to work for individual and collective change by transforming the social context in which they live. The health issues that are covered were diverse and were examined as they affect women. For example, issues such as reproduction, occupational health hazards, sexuality,

violence, drug abuse, and therapy were examined.

Healthsharing was active in organizing around the issue of violence against women. Articles focusing on teenage battering, assault prevention, wife assault and violence against immigrant and minority women encouraged women to speak out about the violence done to them. However, beyond awareness raising, Healthsharing struggled to fight violence against women by providing a network for political action. In an article entitled "Violence And Feminist Strategy" author Varda Burstyn writes:

> One of the things we have to do is seek, beyond our anger, a clear understanding of the causes of violence in our culture. If our strategies merely get at the symptoms, it is likely that they may, like many allopathic drugs, serve to hide the root problems (1984, p. 14).

Health activist Patricia Smyke states that "information is power" (1991, p. 136). Often Canadian women have not had access to the information they need in order to bring about change. The information that Healthsharing provided gave women power by providing the tools to translate their concerns into effective political strategy.

The women who published Healthsharing felt that the information that the magazine presented was not reaching enough women, "with its limited pages and no potential for distribution through corner stores" (McDonnell & Valverde 1985, p. i). In 1982, Healthsharing was one of a group of women's health organizations that initiated the Committee for a Canadian Women's Health Network (McDonnell & Valverde 1985,

p. i). The goals of the Network were to share resources, research, lobby, provide support for women, network, develop a resource bank and provide a wider distribution base for feminist health publications (Ferguson 1992, p. 3). However, "the Committee was short-lived due to a lack of funds and the difficulties associated with being a national organization" (McDonnell & Valverde 1985, P. i).

Despite the demise of the Canadian Women's Health Network, one project was pursued - a Canadian resource book. The Healthsharing Book: Resources for Canadian Women was published in 1985 and became the first and only health resource book for women in Canada. The book provides information on a variety of health topics and gives an annotated listing of organizations across Canada which deal with the presented topics. The book also provides a comprehensive bibliography of reading matter and audio visual material and is an important resource guide for women's health.

The Edmonton Women's Health Collective (EWHC)

The Edmonton Women's Health Collective was formed in 1984 by a small group of women who were committed to promoting the health of women. The Women's Health Collective was based on the following assumptions:

1. That social/economic and political structures influence women's health.

2. That women have specific health needs that need to be recognized and addressed.
3. That women have a right to quality health care appropriate to their needs.
4. That by working collectively women will be empowered to bring about change and to take control of their health (EWHC, 1988).

The Collective worked to "create an environment for education, exploration of issues, skill development, and outreach to women isolated by language, culture, disability or education" (EWHC 1988). The Collective provided a organizational base for women and helped to develop their political awareness in order to organize and mobilize women to act on their own behalf. The Women's Health Collective accomplished this goal by a variety of means. They were: resource collection, workshops, research, information exchange, newsletters, and a practitioner's file "which is a file compiled by women about the kind of care they received from their practitioner" (EWH 1988).

The Collective increased women's awareness to health issues by circulating a monthly newsletter that served as an important source of information for women. The newsletter acted as a forum for information sharing and political advocacy as it encourage women to lobby the government and highlighted the need for women's active participation. The newsletters provided women with information on an overview of issues such as violence against women, child care, reproductive health, pornography and tax reform.

The Women's Health Collective focused on issues that

affect women's daily lives. The Collective encouraged women to deepen their understanding of and to develop their collective strength. This was accomplished by stressing that women cannot operate in a "political wilderness". Women were informed on issues that affected women's participation in public life, social services and health, employment, education and family life.

The Edmonton Women's Health Collective operated for seven years and disbanded in 1991. The Collective operated strictly on a volunteer basis and faced a shortage in financial resources.

The Boston Women's Health Book Collective (BWHBC)

> We are among the women who want to let our longtime experience of being the ones without power shape a vision that challenges the existing power structures themselves. Instead of our own piece of pie, in other words, we want to change the recipe (Stanford & Norsigian 1979, p. 1)

The Boston Women's Health Book Collective publishes a book called Our Bodies, Ourselves. "The collective has, since 1969, helped to radically change the consciousness of women of all classes about their bodies and their health, and has empowered women to take action for their health in many ways" (Beckwith 1985, p. 1). The collective began in 1969, as a women's health discussion group at a Boston conference on women's issues. "In 1969, there was practically no women's health information easily available, and every fact we learned was a revelation" (BWHBC 1992, p. 13). After the conference

the group continued to meet and work to combat the mistreatment of women by health professionals. "The women's health discussion group decided to find out for themselves what they wanted to know about their bodies for themselves, by themselves" (Beckwith 1985, p. 2).

In 1971, the information that the collective gathered was published locally. This information was so well received that in 1972 the information was expanded into a book that by 1985 had sold over 2,000,000 copies in the United States alone (Beckwith 1985, p. 3). The 1972 publication of Our Bodies, Ourselves represents an important milestone in the evolving concept of women's health. This was the first time that any initiative involving women's health had taken women's lived experience as the starting point for a health effort. "One of the cardinal principles of the feminist perspective is attention to the first-person experience of women, it is in the area of women's health ... that full, contextually rich descriptions are most vital because descriptions lead to prescriptions" (McBride & McBride 1982, p. 37).

The collective has and continues to make an impact on women's health; "We saw the tremendous political strength we gained by identifying common problems and standing in unity with one another" (BWHBC 1992, p. 15). The strong focus on a feminist approach to women's health is reflected in the collectives goals. These goals are to provide a wide range of information on women's health, to reflect the needs of women's

different voices, to reach and empower as many women as possible, to support those working for change, and "to work to create a more just society in which good health is a right, not a luxury, a society that does not perpetuate unequal relationships between the sexes" (BWHBC 1992, p. 15).

From the sale of the book Our Bodies, Ourselves, the collective "has used all of its royalties (and other) income to support a variety of women's health projects" (Beckwith 1985, p. 4). One project that the collective has mobilized against is violence against women:

> Over the past fifteen years, women in communities throughout the country have mobilized to offer direct services to women who have encountered violence, to educate people about the range and nature of the violence and to develop strategies for resistance (BWHBC 1992, p. 132).

The collective has organized many different kinds of action opposing violence against women. The following list describes only a portion of the initiatives undertaken by the collective: the organization of consciousness-raising groups, public demonstrations and educational programs for thousands of law enforcement and health professionals, lobbying for new legislation, organized support of women of colour who form groups such as the Committee to End Sterilization Abuse, and helping neighbourhood groups form networks of refuges, called safehouse or greenlight programs (BWHBC 1992, p. 145).

WOMEN'S SHELTERS AND REFUGES

The importance of shelters cannot be overestimated. Shelters stand at the core of the movement to end violence against women, "providing a basis for pragmatic support, political action, and radical renewal" (Dobash and Dobash 1992, p. i). However, there are critics who feel that shelters offer "only band-aid solutions and do not combat the root causes of violence" (Alberta Advisory Council On Women's Issues 1897, p. 2). In response to this criticism it is important to address the functions of women's shelters. Shelters focus on meeting the immediate needs of the women seeking support and assistance. This initial and primary response is required due to the "unwillingness or inability of social, legal and medical agencies to act effectively to assist women after abuse" (Dobash and Dobash 1992, p. 11). Beyond this central goal concerning the protection of abused women, there is tremendous diversity in individual shelters and their focus on social change. Some shelters focus on political work and social service whereas others primarily focus on service provision. However, all women's shelters and refuges reject violence. The intention here is to examine the ways that shelters challenge "gender inequalities in the domestic, economic, and political arenas that form the foundation of and provide support for male violence" (Dobash and Dobash 1992, p. 28).

The first refuge for battered women opened in Britain in

1972 and quickly spread nationally and internationally. From this base, women have challenged the police, courts and social services to provide greater assistance to women. Emergency shelters have played a key role in bringing the issue of violence against women to public attention and "organizing a pragmatic response to assisting women on a wider philosophy of feminist inspired change" (Dobash and Dobash 1992, p. 1).

As stated earlier the refuge stands at the heart of the social movement to end violence against women. In the book Women, Violence & Social Change, Rebecca and Russell Dobash (1992) provide several reasons why shelters are critical:

> For the woman, it serves as a physical place where she can temporarily escape from violence, find safety and make decisions about her own life. Contact with other women helps overcome isolation and a sense of being the only one with a violent partner. For the movement, it provides the physical location from which to organize, and serves as a base for practical and political thought and action (p. 60).

The above quotation illustrates the ways that shelters act as a place of respite by providing a temporary environment for women, and also how shelters also provide a location where action can be initiated. Refuges provide a powerful base where attempts are made to reorder the wider social conditions that underpin male violence:

> Thus, the refuge itself becomes a fundamental means by which feminist politics is developed, sustained and rekindled within the context of the problem itself and in close contact with the daily lives of its sufferers. The refuge provides an almost unique opportunity for creating change for women that not only assists women who have been battered but also stretches beyond those who seek refuge.

> The provision of a physical space so thoroughly enmeshed in the problem itself and in the lives of the women and the refuge workers is unique for most social movements, and it is doubtful that a movement, rather than just a provision of service, could have developed or been sustained without it (Dobash and Dobash 1992, p. 60).

The general function of the refuge is beyond assisting abused women, refuges actively reject patriarchal control of women. The activist orientation of shelters is directed at the grassroot level. A wide political view is taken of the roots of the problem of violence against women and the necessity for far reaching changes to deal with both the individuals concerned and the social supports underpinning violence against women.

SUMMARY

This chapter has begun to explore women's concept of health and the principles on which it is based. "The calculus on which women's health rests, however, has yet to be fully articulated" (Christiansen-Ruffman 1987, p. 13). We have only begun to specify the parameters of women's concept of health. Therefore, health educators must gain an understanding of the differences between a feminist and a patriarchal concept of health and use this knowledge to develop health strategies that promote the well-being of all people.

By drawing together various threads of feminist organizations that are committed to working against violence against women, the cloth that is woven will be strong enough

to create social norms that define violence against women as unacceptable. Feminism has provided strong concepts about the status of women and women's health which are crucial to health promotion and which help in the understanding and analysis of everyday situations. As a first step towards improving the health of women, a feminist perspective needs to be critically examined by health professionals.

CHAPTER V

CONCLUSION AND IMPLICATIONS

CONCLUSIONS

The conclusions of this study are responses to the research questions which were posed in Chapter One.

1. What do mainstream health documents say about well-being and violence against women?

The three mainstream health documents that were analyzed in Chapter Three failed to adequately address violence against women as a major health issue. The token inclusion or acknowledgement of violence as a health problem is evident in all three documents.

Achieving Health For All: A Framework For Health Promotion is an important document as it establishes a blueprint or framework for health promotion efforts. The Framework overwhelmingly emphasises individual behaviours which minimizes the understanding that health is influenced by a broad range of factors, such as the social and physical environment in which people live. The Framework measures health promotion predominantly in terms of individual strategies and behaviours. The Framework fails to designate violence against women as a national health challenge or problem and does not acknowledge the negative impact of violence on the general level of well-being.

The remaining two health documents focused specifically on women's health. Issues And Priorities For Women's Health In Canada: A Key Informant Survey identified violence against women as one of six key health issues. Yet, the discussion which focused on violence against women was limited and there were few changes or priorities identified in this area. This response was discouraging as this survey was a strategy paper that was used to formulate long term program plans in the area of women's health.

The Active Health Report On Women completely excluded the issue of violence against women from its survey which severely limits the accuracy of the report. By excluding violence, an issue that had previously been identified as a key health issue for women, the report remains severely limited in its scope. A second major flaw in the report is the exclusive emphasis on individual-level determinants of health. The report fails to address health promotion efforts beyond individual women and ignores the social environment within which women live.

2. What are the implications of women's fear of violence to their participation in physical activity?

The identification of fear of violence as a constraint to active lifestyles for females was established based on the experiences of five female athletes and was further supported by data on safety in women's leisure. The implications of

women's fear of violence to their participation in physical activity is as follows:

a. Female athletes often experience anxiety over their personal safety and therefore do not optimally benefit, physically or psychologically, from participating in physical activity.

b. Careful planning and organizing is often required prior to women's involvement in physical activity in order to ensure one's safety.

c. Loss of a sense of freedom in an activity as circumscriptions are placed on independent leisure.

d. Female athletes often negotiate their safety by altering or withdrawing from physical activity.

3. What are the individual strategies used by women in order to participate in physical activity despite fears of violence?

Avoidance strategies that are employed by women runners are as follows:

a. If running alone avoid unpopulated areas such as bike trails.

b. Run in familiar areas.

c. Run in the daylight and avoid running early in the morning or late evenings.

d. Run with a partner or a large dog when running in unpopulated areas. Carry bear spray.

e. Carefully plan the route and stay alert.

f. If it is too late to run, participate in an alternate activity.

4. What do feminist health materials say about well-being and violence against women?

Feminist health materials clearly identify violence against women as a leading health concern. Feminist health educators propose a more holistic approach to women's well-being by broadening health promotion to include the political, economic and legal issues that prevent or limit women's achievement of their full potential. Feminist health promotion is not solely focused on women's individual lifestyles but is primarily focused on societal-level determinants of health.

A major distinguishing feature between mainstream and feminist health promotion is that with feminist health promotion social change is foremost. Feminist health materials acknowledge violence as a major health problem and then design and implement comprehensive strategies for addressing the problem of violence against women. Feminists work to create a more just, egalitarian and humane society by targeting the societal factors which complicate women's struggle to achieve well-being.

5. What are the implications to women's well-being , as they participate in physical activity, of not having violence against women included in mainstream materials?

Violence has a direct and powerful bearing on women's well-being, particularly within sport-related contexts. Many women participate in physical activity to improve their well-being, yet the fear of violence often prevents women's full participation in physical activity (Lenskyj 1992, p. 19). As outlined earlier, it is difficult for women to fully participate or to achieve a desired level of satisfaction if fear exists.

Often women's leisure experiences become highly constrained in order to participate safely in physical activity. As long as women experience fear while participating in physical activity, leisure will continue to be absent as a significant force in many women's lives (Deem 1986, p. 66). This is a significant limitation to women's well-being as it is difficult for women to realize their full physical potential.

Fear needs to be further examined in understanding women's leisure constraints more fully. However, this requires the acknowledgement of violence against women within mainstream health materials in order to establish a framework for understanding violence against women in a more encompassing way. The contexts of women's lives and the society in which women live needs to be considered in order to

devise strategies and policies for social change.

IMPLICATIONS FOR HEALTH EDUCATORS

To encourage health educators to acknowledge the broader social context of women's lives the following actions are suggested:

a) A feminist analysis of health in order to bring to light the issue of violence against women. A gender analysis would prove useful in reinterpreting and expanding understanding of women's health and well-being.

b) As a starting point for a critique of women's health research must be focused on women's everyday lives, specifically altering the scope from personal characteristics to a focus on social circumstances.

c) Develop a new framework for health promotion which includes the impact of acts of violence and will provide a better understanding of obstacles to well-being.

d) Contemporary health documents need to be analyzed in terms of the extent to which they might reinforce or challenge wider social structures. This would lead to a greater sensitivity to the implications of current health promotion strategies.

IMPLICATIONS FOR PHYSICAL EDUCATORS

To encourage physical educators to develop safe environments for women's leisure many actions might be taken.

They include:

a) Fear needs to be further examined in understanding women's leisure constraints more fully.

b) An affirmation of the importance of providing safe women's leisure to contribute to an enhanced quality of life.

c) More effective planning would encourage women's leisure outside of the home. For example, "street and footpath design and lighting can make an enormous difference to whether women feel safe outside the home in the day and after dark" (Deem 1986, p. 142).

It is hoped that this study has substantiated the premise that violence against women is a major obstacle in women's struggle for well-being and therefore violence against women needs to be addressed extensively by health educators. It is also evident that physical activity has an important role to play in the search for well-being. Perhaps this is an indication, that given safe opportunities for leisure outside the home, more women would readily participate in physical activity and benefit from the improvements to well-being and fitness. However, the problem of violence against women must be addressed within mainstream health documents if women are to achieve their full potential. Obviously more research and reflections are necessary related specifically to violence against women and the impact on women's health and well-being.

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APPENDIX A

INFORMED CONSENT

University of Alberta

Department of Physical Education and Sport Studies

INFORMED CONSENT

Research Project Title: Women And The Struggle For Well-Being

Investigators: Cathy van Ingen (430-9375) Dr. D. Shogan (942-1023)

The purpose of this study is to focus on violence against women by strangers and determine ways in which this effects women's involvement in physical activity. I am interested in your involvement in physical activity and on the types of strategies you use in order to participate safely in physical activity despite fears of violence. You have been identified as an active participant in a physical activity. Your participation is completely voluntary.

Each subject will be interviewed in an informal group setting with five other female athletes. The interview will take approximately one hour and take the format of a group discussion. During these interviews you will be asked to describe your involvement in physical activity and any experience with fear and anxiety that you have encountered in relation to your participation in this activity. These interviews will be audio-taped and later transcribed. In order to protect anonymity, the tapes and their associated transcripts will be assigned a pseudo name and locked in a filing cabinet. After the interview the information gained from your participation will be made available to you, so that you may comment on the accuracy of the investigators interpretation of your data. Following my oral defense the tapes, transcripts and field notes will be destroyed.

The final research project, including anonymous quotations will be available to all participants, and will be presented as part of a M.A. thesis. The research findings may be published in a journal but the anonymity and confidentiality of the subjects will be ensured. Although there may be no direct benefits to participants in this study, the research findings may contribute to physical/health educators understanding of the ways in which to promote physical activity for women.

If you have any further questions about this research please contact either Cathy van Ingen (430-9375) or Dr. D. Shogan (492-1023).

Women And The Struggle For Well-Being
INFORMED CONSENT FORM

This is to certify that I,_____ (print name) hereby agree to participate in the above named project.

I hereby give permission to be interviewed, and for those interviews to be recorded on audio-tape. I understand that following the researcher's oral defense the tapes, transcripts and field notes will be destroyed. I understand that the information may be published, but my name will be kept anonymous and confidential.

I understand that I am free to refuse to answer questions during the interview. I also understand that I am free to withdraw my consent and terminate my participation in this project at any time without penalty. I have been given the opportunity to ask whatever questions I desire, and they have been answered to my satisfaction. I acknowledge receipt of this consent form.

Signed,

_____	_____	_____
Participant	Witness	Researcher

_____
Date

APPENDIX B

"Women Running Smart"

THE RUNNING ROOM -EDMONTON

Running Room®

CANADA SPORT'S SPECIALISTS

WOMEN RUNNING SMART

GUIDELINES FOR STREETWISE RUNNERS AND JOGGERS

The following tips are recommended by the Edmonton Police Service

- Carry identification or write your name, phone number, and blood type on the inside sole or lace to the outsid of your running shoe. Include medical information.
- Don't wear jewellery.
- Carry a quarter for a phone call.
- Run with a partner.
- Write down or leave word of your running route. Inform your friends and family of your favorite routes.
- Run in familiar areas. Know the location of telephones and open businesses and stores. Alter your route pattern.
- Always stay alert. The more aware you are, the less vulnerable you are.
- Avoid unpopulated areas, deserted streets, and overgrown trails. Especially avoid unlit areas at night. Run clear of parked cars and bushes.
- Don't wear headphones. Use your hearing to be aware of your surroundings.
- Ignore verbal harassment. Use discretion in acknowledging strangers. Look directly at others and be observant, but keep your distance and keep moving.
- Run against traffic so you can observe approaching automobiles.
- Wear reflective material if you must run before dawn or after dark.
- Use your intuition about suspicious persons or areas. React on your intuition and avoid any person or area that feels unsafe to you.
- Carry a whistle or a noisemaker.
- Call the police immediately if something happens to you or someone else, or if you notice anyone out of the ordinary during your run.

For more information call the Edmonton Police Service, Crime Prevention Unit, at 421-3475

Notes: _____